GEORGE BURGESS MAGRATH

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George Burgess Magrath, 1870-1938

Memorial on the death of George Burgess Magrath spread on the Records of the Faculty of Medicine, February 3, 1939.

Born October 2, 1870 in Jackson, Michigan, son of the Reverend John Thomas and Sarah Jane (Herrick) Magrath, George Burgess Magrath moved to Brattle Creek, Michigan, at the age of seven, to a suburb of Philadelphia two years later and to Hyde Park, a suburb of Boston, at the age of twelve. His father was rector first of the Episcopal Church in Hyde Park and later of the Church of the Holy Spirit in Mattapan, where Dr. Magrath became organist, thus early evincing an interest in music that followed him through life as an avocation expressed in active participation in the Cecilia Society, the Handel and Hayden Society, the Harvard Alumni Chorus and the Sängerfest and in regular attendance at The Symphony Concerts.

Dr. Magrath spent three years in Hyde Park High School, graduated at the head of his class from Roxbury Latin School at the end of one year more and then entered Harvard, graduating A.B. *magna cum laude*, 1894, M.D. *cum laude*, 1898 and A.M. 1899. From his graduation to his death he was a member of the teaching force in the Harvard Medical School as follows:

1898-1900 Assistant in Pathology
1900-1901—Austin Teaching Fellow in Pathology
1901-1905 Assistant in Pathology
1905-1909 Assistant in Hygiene
1907-1931 Instructor in Legal Medicine
1931-1937 Professor of Legal Medicine
After Sept, 1, 1937 Professor Emeritus

Dr. Magrath was a very excellent teacher. In his earlier days in pathology his demonstrations were popular with students. He was enthusiastic, systematic and clear in didactic teaching, a quality which became even more evident in his lectures later on, when he was giving instruction in legal medicine. These he aptly, often dramatically, illustrated from his personal experience in a way to make remembered the facts he was bringing to his class.

Trained under Councilman and Mallory and with practical experience at the Long Island, the Carney, the Cambridge, the Faulkner and St. Elizabeth's hospitals, Dr. Magrath became an excellent pathologist. His technique in the performance of an autopsy was masterly, and his keen observation recorded many details, some of which might, and often did, prove of the greatest importance in fixing the responsibility for a crime of violence. In his earlier work, when he was assistant to the secretary of the Massachusetts Board of Health, he began to show qualities, which made so successful his long years in the office of Medical Examiner. He was set to study the adulteration of sausages. Treating these as a body tissue, he hardened, embedded, sectioned and stained. The paucity of striated muscle fibers and the excess of starch granules, which he identified as corn meal, were convincing evidence of the richness of the adulteration of the original sausage.

In 1907 Governor Curtis Guild appointed Dr. Magrath Medical Examiner of the Northern District of Boston, an office which had been created in 1877 and for thirty years had been held by Dr. F. A. Harris. For the next twenty-eight years Dr. Magrath competently filled that position. In this office Dr. Magrath rapidly became recognized as a leading expert in New England in the solution of the problems of crime by violence. His fine basic training in pathology, his skill and exactness in post-mortem examinations, his logical processes of thought and exposition, his intellectual independence, his unquestioned honesty and courage, made of him an expert in court and out, whose opinions carried the greatest weight. To be cross ex-

amined was a challenge to his knowledge and intellectual acumen which he enjoyed; rarely could he be caught unawares by opposing legal talent. More and more were his advice and his opinions sought beyond the bounds of his own district; more and more was his help asked by others in similar offices, so that his influence in legal medicine steadily increased. When New York City was planning changes in its plan of legal medical work, Dr. Magrath was an important advisor.

During Dr. Magrath's twenty-eight years as Medical Examiner he established many important procedures and made precedents, which now largely have become recognized as determining factors of the work of Medical Examiners in relation to Legal Medicine. In this way and by his own individual work Dr. Magrath had an important part in the development here of legal medicine into a science and art deserving of recognition as a significant department of medicine, a development, which started by Dr. Magrath and furthered by the generosity of Mrs. Lee, may be expected to expand and progress under succeeding professors of legal medicine until Harvard will have an actual Institute in which all phases of the many sided problems of Legal Medicine can be investigated, taught and practiced.

In person Dr. Magrath was a picturesque figure, about which gathered many legends. He was erect and broad chested; with shoulders thrown back and chest forward he created the atmosphere of great physical strength, which in fact he had, as exemplified by his prowess as an oarsman, he for many years appearing as an oarsman, not alone on the Charles for recreation but in crews in various races, often winning both on the Charles and Schuylkill Rivers. His mane of hair, first red, then grayish, eventually white, towered over a broad brow and finely chiselled features. These with his habitually worn flowing Windsor tie gave him the appearance of musician or artist rather than medical man. Dr. Magrath was genial, enjoyed social intercourse and was much beloved by a wide circle of friends. Under the exterior that might seem brusque there lurked gentleness and a great sympathetic kindliness, often commented upon by those with whom Dr. Magrath came into contact by reasons of the requirements of his office of medical examiner; what had seemed in advance an ordeal to be faced turned out often to be no ordeal at all on account of these qualities of Dr. Magrath.

Dr. Magrath died on December 11, 1938, after a brief illness, respected by the Commonwealth of Massachusetts and by Harvard University, both of which he had served so well for so long, and loved by a very large circle of devoted friends, lay and medical.

Almost the last thing that Dr. Magrath did was to dictate to his Secretary a "New Year's Salutation" which appeared on the Editorial page of the *American Journal of Medical Jurisprudence,* volume 2, No. 1, page 55, January, 1939. This was dictated the day before he died. Part of this is appended, since it states Dr. Magrath's views of the best development of the Medical Examiner system in which he had taken so great interest throughout his life.

"The history of the foundation of the Medical Examiner system in this state and some of the statutes pertaining thereto have been well presented by capable writers in these pages, but the fact remains that the system of today, governed by these very statutes enacted at a time when we were bound by transportation difficulties no longer existing, needs further changes and improvement. The Central Office system patterned after the system existing today in parts of continental Europe would, in my opinion, in many ways be an improvement over the Medical Examiner system now employed in Massachusetts. Mainly, however, in the coöperation it could bring about between the highly trained, scientific investigator and pathologist as found in the large cities and universities and the medical examiner of the small town districts

who is necessarily handicapped by the lack of experience and proper operating facilities.

"Such a system roughly consisting of one Chief Medical Examiner, two Assistants, two Associates, and several Deputies would, in my estimation, with no reduction in personnel, vastly increase the efficiency and at the same time prove less expensive than our present system. Realizing that there will be those who disagree with this idea, we again state that it is our hope that one of the important functions of *The American Journal of Medical Jurisprudence* will be to bring about an open discussion of all problems and trust that this will be only one of many topics which we may be able to present in our readers' columns."

Respectfully submitted,
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MYRTELLE M. CANAVAN,
S. BURT WOLBACH.

Our Private Medical Services

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The merits of the present system of individualistic medical care and the quality of medicine dispensed under it have been defended so frequently by various representatives of the medical profession that commendation of it here would serve little purpose. Inadequacies, of course, exist. The frank recognition of them and discussion of means of correcting them is one method of evolving constructive thought toward the provision of better medical care.

The first and, perhaps, the most popularly recognized inadequacy of our present system concerns the manner in which the costs of private medical services are met. In this day of expensive medicine it is a generally accepted premise that the average patient should not be expected to meet the costs of serious illness at the time they are incurred. Since everyone needs medical attention at some time during his life, a logical budgeting for illness would be accomplished by applying the principle of prepayment cost sharing as widely as possible. Even with an adequate distribution of costs and an efficient organization of medical services, the quality of medicine that can be attained probably will be limited by what society can afford to pay. But so long as good medicine continues to reduce the costs of illness to society, even if it increases the cost per sick individual, what is an impossible extravagance for the individual may become a realizable economy to the nation. The evidence indicates that the application of the prepayment principle is growing. No data at hand suggest that application of this principle to medical costs is per se either economically unsound or detrimental to the quality of medicine. However, since the quality of medicine should always be of prime concern to the medical profession, the extension of the principle should be accomplished with due regard to the establishment and maintenance of standards of quality. Nevertheless, official representatives of the medical profession have shown little initiative to this end and have opposed the application of this principle except under narrow and possibly unwise limitations, as indicated briefly in the following paragraphs.

Several years ago so-called "lodge" or "contract" practice was tried and abused, yet an increasing demand for distribution of medical costs arose. Insurance for hospital care was well under way in 1932. Prepayment medical groups sprang up here and there. The House of Delegates of the

American Medical Association in 1933 did not approve the Majority Report of the Committee on the Costs of Medical Care which recommended that medical service be furnished largely by groups of physicians organized preferably around hospitals and costs of medical care be placed on a group payment basis, but adopted Minority Report No. 1. In 1934 the House of Delegates adopted ten fundamental principles as basic to a high quality of medical service. Three of them deserve mention here:

Fourth: The method of giving the service must retain a permanent confidential relation between the patient and a "family physician". This relation must be the fundamental and dominating feature of any system.

Sixth: However the cost of medical service must be distributed the immediate cost should be borne by the patient, if able to pay, at the time the service is rendered.

Seventh: Medical service must have no connection with any cash benefits.

In the same year the Judicial Council of the American Medical Association reprimanded the American College of Surgeons for promulgating a prepayment plan for medical care at approved hospitals to members of the staffs of such hospitals and to physicians acceptable to such staffs.

Doctors Ross and Loos were expelled from the Los Angeles County Medical Association and the California Medical Association because of their operation of a group prepayment medical service. Subsequent investigation revealed that:

"The appellants were brought to trial with no definite knowledge of what they were charged: they had no adequate opportunity to defend themselves; they were expelled for some unknown act not appearing in the charges, and they did not have a fair trial." (J. Amer. Med. Ass., 1936, 106:301)

Doctors Ross and Loos were later reinstated.

The discussion of the Principles and Proposals of the Committee of Physicians is probably familiar, in one aspect or another, to most physicians. The Proposals pertained to the medical care given the indigent by the large clinics. Their purpose was to provide a conservative means of financing these clinics so that the quality of their medicine, teaching and research might be maintained. The following excerpts taken from remarks made by Dr. Fishbein in the fall of 1937 to representatives of the public press (Minnesota Medicine, 1937, *20*: 795) may not be familiar and call to mind an attitude of the official spokesmen of the American Medical Association at that time.

"The new threat—the so-called 'split' in the American Medical Association occasioned by the petition of the 'Committee of Physicians' and signed by the now famous 430—is more insidious than any of those that preceded it. * * * The object is to get as many good names as possible so that Congress and the public will believe in the split. The methods are questionable. The action of the men who thoughtlessly lend their names to the project is worse than questionable. * * * In Russia, and in the United States, if the 430 signers have their way, all matters relating to the distribution of medical care, are to be in the hands of 'experts'. * * * What do the proposals of the Committee of Physicians and all advocates of State Medicine offer the physician?"

When the report of the California Medical-Economic Survey was published by the medical association, the comments of the director and the chapter headed Conclusions and Recommendations were omitted. The Journal of the American Medical Association commented (1938, *110*:117B):

"There is a tendency throughout the published tables to exaggerate the lack of medical care, the cost of such services and the implied defects of the medical profession. * * * The tables and figures in this report give the reader the impression that there has been an effort to arrange a build-up for sickness insurance."

Later the Journal (1938, *110*:230B) in commenting on medical problems in California stated:

"There are continuous efforts to induce county medical societies to organize prepayment medical service groups, but so far these have been successfully discouraged."

The House of Delegates in June, 1938, reiterated the ten fundamental principles of 1934, adding a recommendation which seems to clash somewhat with principle 7; namely,

"That the American Medical Association adopt the principle that in any place or arrangement for the provision of medical services the benefits shall be paid in cash directly to the individual member. Thus, all direct control of medical services may be avoided. Cash benefits only will not disturb or alter the relations of patients, physicians and hospitals."

Then came the National Health Conference, the Program of the Technical Committee, and the special meeting of the House of Delegates in September. The principal of prepayment cost-sharing was accepted by the American Medical Association. The application of the principle to the indigent by means of taxation and to those who can finance voluntary prepayment schemes was approved. But the means by which a distribution of the costs of medical care incurred by the intermediate low income group, who are neither indigent nor financially able to pay the costs of voluntary schemes, remains for consideration. This is the very group which reports from the American Medical Association's current survey of medical care show is receiving inadequate medical service. Surely the individuals of this group should not receive care as indigents. If they do, the number of individuals in the combined groups would approximate 75 million. They should and can assume a portion of the costs, but they cannot afford any voluntary scheme yet devised that provides complete medical care of a proper quality. There are those that advocate state compulsory insurance for this group. The American Medical Association and most of the State Medical Associations oppose state compulsory insurance. The problem is difficult. Time and the experience derived from providing tax suppported medicine for some 30 million medical indigent and voluntary prepayment schemes for the high income groups should be helpful in arriving at a satisfactory solution of the problem. Unfortunately the consumer group concerned may become impatient.

The medical profession still limits voluntary prepayment schemes to rather circumscribed patterns, which some evidence suggests do not meet the needs of economy and high standards. The extreme position taken by official representatives of medical associations in opposing the voluntary non-profit scheme operated by Group Health Association, Washington, D. C., can be found in the Journal of the A.M.A. (1937, *109*; 39-B) or in an abbreviated form in the New England Journal of Medicine (1938, *218*; 130). Unfortunately, the manner of their opposition has resulted in a grand jury indictment not only of the individuals but also of the American Medical Association. The Journal of the American Medical Association commented editorially (1938, *111*: 2492):

"Physicians should remember in the meantime that every action of the Association has had the approval of the House of Delegates; that every step has been in the interest of advancing medical science and the quality of medical service for all the people; that the House of Delegates has already authorized the Board of Trustees to fight this case to the courts of last resort to determine the issue."

It is pertinent to a consideration of the attitude of the medical profession toward prepayment schemes in general that in this particular case the acts that led to the indictment of the American Medical Association were never directed or sponsored by the House of Delegates of the American Medical Association. Possibly the House of Delegates has approved only the every action of the Association and not every act of the individuals who have brought this indictment on their Association. Certainly there are many members of the American Medical Association who neither disapprove of such prepayment schemes as Group Health Association nor approve of the methods by which opposition to them have been effected. Appraisal of the extent of such opinion is difficult because there is but little opportunity within the profession for the expression of minority opinion. Incongruously enough the idea has crept into our democratic medical organizations that the medical profession must maintain a unanimity of opinion and

a so-called "solid front" on many subjects concerning which our present knowledge is so incomplete that differences of opinion are natural and healthy and unanimity is artificial and unwholesome.

The record thus suggests: i, that our present system includes no adequate provision for distribution of costs; and ii, that the organized medical profession has given little encouragement to the gradual incorporation of distribution schemes into medical service. Though it is true that medicine is not a commodity that can be purchased in the market-place by the individual for so many dollars and cents, it is equally true today that good medicine cannot be had by society as a whole unless it is adequately financed. Concern over the distribution of medical costs does not arise from sentimental social theory. It is forced upon us in an effort to ensure a high quality of medical care by the provision of adequate financial support. Can a high quality of service, reasonably in line with medical knowledge, be rendered without drawing more generally than at present on all those who are not momentarily burdened with illness? If there are other means, they should be brought forward; if not, then the problem is to provide a means of distributing costs that will permit and not defeat the attainment of the desired end.

Constructive steps can be taken with but little change in existing conditions. Many able and respected private practitioners who have graduated from this school do not conform to principle six of the American Medical Association nor the cash indemnity principle of insurance in charging their private patients for their professional services. They are charging many of their patients a yearly fee for medical services. If patients can thus pay individual physicians, why cannot groups of patients thus pay groups of physicians for medical care? Let us assume that the organization of prepayment groups may necessitate some salaried physicians. Are there not many salaried physicians now working in large private and charity clinics, in Harvard and other University medical services, and in industrial health schemes? There are also many young doctors working for the older private practitioners and receiving salaries from them. Can it be maintained that the average service given by the Army and Navy physicians, all on salary, is poorer than the *average* medicine given by the doctor who sends a bill for as much as he thinks the patient will pay and then per chance collects in full, or accepts half, or calls in a collecting agency? And is the former manner of receiving recompense for medical services less befitting the dignity of the medical profession than the latter?

A second inadequacy in the present system is the lack of differentiation between the competent and the incompetent physician. Some of the difficulty lies undoubtedly with the public. The medical profession has striven to eliminate the improperly qualified doctor by raising the standards of medical schools, and the requirements for licensing, and often has received but little support from the public. Poor or bad medical schools continue to graduate poor doctors who, without adequate interneships are licensed to practise. Qualified boards within the profession have classified the well qualified specialist by certification in special fields. But, in spite of these attempts, the fact remains that most laymen have great difficulty in distinguishing between the qualified and the unqualified physician. Possibly the difficulty is inherent in the individualistic character of our private practice. Has the profession done enough to help both doctors and laymen in the selection of properly qualified physicians or has the profession been timid about criticizing poor medical care? If the profession adopts the attitude that things are better in this respect under the existing system than they would be under any other, at least some burden of evidence for this attitude rests on it. To say that we have a better grade of medical care in the United States than in any other country does not answer the question.

A third inadequacy is the lack of organization of medical services. The rapid increase in medical knowledge and facilities has created a need for organization in the interest of economy and efficiency. A sound approach to the problem is provided by the recognition of the validity of two statements which appear paradoxical when considered superficially. First, medical knowledge and science have grown beyond the capacity of the individual physician. Second, eighty per cent of illness can be cared for properly by the general practitioner. On the one hand, there are the recognized specialists trained to apply special knowledge and techniques to the diagnosis and treatment of disease; on the other hand, there is the family practitioner who cares for the many illnesses that do not demand special technical knowledge but nonetheless require a high quality of clinical experience and ability. It is as inefficient to have the highly skilled specialist caring for minor illnesses as to have the family practitioner treating illness that demands knowledge and techniques with which he is not thoroughly familiar.

Attempts to organize medical services must include all aspects of its science, its "art", personal relations, techniques and physical equipment. The inclusion of all these makes the problem of organization difficult. But it need not follow that regimentation is implicit in organization, particularly if the oganization be accomplished by physicians; nor that the family physician will be discarded. He should still care for the eighty per cent of illness for which he is the specialist and by his skill recognize the twenty per cent that is best handled by other specialists.

There is a natural and increasing tendency for the recognized specialist to become associated with large clinics. This is probably as it should be. It favors their continued education as well as the economical utilization of assistants and modern expensive technical equipment, which, like operating rooms, is more and more centered in hospitals. There should be no antagonism between these specialists of the large clinics and the family practitioners. The services of the one supplement those of the other in fields so vast that neither alone is adequate. The former make available to the practitioner diagnostic services and special treatment. They introduce new methods of medical and surgical diagnosis and therapy. They staff teaching clinics, publish results of their special investigations, speak before medical societies, and thus give gratuitously to the general practioner the new medical knowledge that each succeeding year becomes his stock in trade. On the other hand, many practitioners give much of their time to the clinics, thus providing them with the experience that they alone possess. The mutual dependence of these two groups of physicians is evident. Yet there is a lack of coördination and at times of coöperation between them.

On the one hand, private patients in the home or private wing of the large clinic too frequently may miss the special knowledge or techniques available within the clinic or obtain them only at a cost that is almost prohibitive. On the other hand, the charity patients in the large clinics get the full benefit of the special knowledge and technical facilities provided by it; but they miss too frequently the benefit of medical care dependent upon an intimate and continued relation between doctors and patients. That this inadequacy is not inherent in hospital or clinic medicine is shown by the extraordinary extent to which a satisfactory relation of this kind is established even under existing circumstances, where lack of contact in the home, the rapid turnover of the house officers and younger resident physicians, and the limited and meagerly paid associate and visiting staff physicians, who usually are on service intermittently, make the provision of this type of care difficult. The social service department in some clinics does much to bridge this gap; but the personnel of this department is usually inadequate for the task.

Under the present system where physicians give their services to non-profit hospitals with little or no remuneration, the practitioner with some justice resents an increase in the number of self-supporting persons removed from his field of practice to treatment in the clinics on a basis of at least partial charity. If physicians were properly paid for the services they now render to these hospitals and provisions were made for including more qualified practitioners on the staffs of hospitals, this resentment would largely disappear; with the coöperation and participation of the practitioners expansion of the services of the large clinics and hospitals could be accomplished. The successful practitioners no longer would give less and less time to the clinic, as their knowledge and private practice developed, in order that they, by taxing their well to do patients (quite fairly under the present system), might finally be recompensed for the time devoted to charity medicine. And the less successful practitioners, whose incomes are inadequate for their family responsibilities, would not be asked to do a great deal of charity work. While the performance of such work may be, as remarked in the Dodd and Penrose report, "greatly to the credit of their personal character it is not proper public policy to permit this dilemma to impale physicians on the one horn and the needy public on the other."

Adequately financed, our large hospitals would possess potentialities of providing a high quality of medical care more economically and efficiently than can be envisaged as deriving from any other existing medical resources. They would embody the essential components of good medical care, namely: 1, provision for education of the young doctor and continued education of the older physician; 2, an environment for medical research; 3, services of the general practitioner; 4, services of the specialists and consultants; 5, access to modern diagnostic and therapeutic facilities; 6, provision for hospitalization; and 7, the machinery for effective coöperation with public health services. The ready applicability of such centers to the provision of philanthropically and tax supported medicine to the indigent and group prepayment medicine to the higher income groups renders them particularly suited to the economic problems that confront medicine today. Possibly it also provides a most conservative way of meeting these problems.

Experience has shown that the practice of tax supported and prepayment medicine by individual physicians paid on a fee-for-service basis does not encourage efficient and economical medical care. Under such a system educational contacts are made with difficulty by the average physician. Efficiency and economy in the distribution and application of special facilities are not favored. Consultant and specialist services are expensive. Hospitalization, even where covered by hospital insurance, tends to be either excessively costly or pauperizing. The individualistic competitive character of the system limits coöperation between the physicians and the public health services.

The American Medical Association long has recognized the incompatibility of individualistic fee-for-service practice and tax supported and prepayment medicine. Its desire to defend the former explains its opposition to the latter. But now that the Association has advocated these two forms of financing medicine, it must permit the development of forms of practice suitable to the new needs. There is danger that tradition, habit, sentiment, inertia, and vested interests will tend to favor the application of individual fee-for-service practice to tax supported medicine and prepayment medicine. If this occurs, the medical services rendered almost certainly will be limited in order to avoid the extravagant costs recently encountered by the City of San Francisco and our medicine will then embrace all the faults for which the American Medical Association has condemned the British panel system.

The Jew—His Racial Status

An Anthropological Appraisal

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This paper is concerned with the racial origin, development, and present status of the Jewish people. Never before has this essentially biological aspect of the Jew become of such singular importance to the Jew himself and to the world at large. The growth of nationalism, fascism, and race consciousness throughout all parts of the globe, has made it imperative that the unbiased physical anthropologist speak of these matters in a detached and purely scientific manner. It is the physical anthropologist, not the politician, nor the demagogue, nor the propagandist, who is the one who is competent to speak of race in the true sense of the word.

What is meant by the term "race"? I can think of no other term which has suffered and is still suffering, such abuse in the hands of the laymen. We often hear people refer to the "Negro" race, the "Jewish" race, the "Scandinavian" race, the "Latin" race. Let us analyze the meanings and inferences contained in these terms. When we speak of the "Negro race," race then becomes primarily a matter of skin pigmentation. When we speak of the "Jewish race", race then becomes a matter of religion. When we speak of the "Scandinavian race" the criterion for race becomes a question of geographical position. The "Latin race", finally contains a linguistic implication. To the physical anthropologist, the word and the criteria of "race" are based simply on combinations of physical characteristics. The term "race", then, refers to a biological classification of *Homo sapiens* irrespective of any and all linguistic, religious, geographical, and temperamental considerations. In technical language a race may be defined as a great division of mankind, the members of which show similar or identical combinations of physical features which they owe to their common heredity. We group individuals into the same race when they have similar physical characteristics of pigmentation, hair, eyes, skin, shape of head, form of nose and the like, inherited from the same group of ancestors. The physical criteria used in racial groupings are those features which are heritable and mainly non-adaptive and which are very little, if at all, subject to change of differing environments. It is these heritable physical features which make the mating of Negro and Negro produce nothing but Negro children, which cause White children to spring only from White parents, and Mongoloid children only from Mongoloid parents.

Now in the world today, there exists no perfectly pure race in the strict sense of the term. When we arbitrarily set up physical standards as criteria of a certain race, it does not necessarily mean that every individual in the racial group so designated possesses all of the criteria without exception. What is usually the case, is that the individuals so classified possess in common the great majority of the features of the racial group. Some do show all of the features and the remainder show most of the characteristics. The finer the classification of *Homo sapiens* into race groups, the less pure such racial categories are. Thus, the purity of stock of the four great divisions of mankind—Negroid, Mongoloid, White and Australoid, is considerably greater than any of the subdivisions of the aforementioned.

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As regards the great "White" division, the anthropologist distinguishes several primary and several secondary sub-races. The most important of these primary sub-races are the Mediterranean, the Nordic, the Alpine, and it is possible that peoples of the Iranian Plateau may be added to this group. Secondary "White" sub-races are the Keltic, Dinaric, East Baltic, Berber and others. Although it is true that most of the countries of western Europe are almost "pure" as far as their being classified in the "White" division of mankind, no nation approaches any semblance of purity as far as the sub-races are concerned. Every nation is composed of a mixture, to a greater or less degree of several primary or secondary racial strains. In other words, all nations consist of racially mixed individuals. The English, for example, are not a pure race in the anthropological sense of the word. They cannot be said to be a race at all. They are a conglomerate mixture of many diversified "White" sub-races. Although they do possess a Nordic element within their population, they have far less claim to being called a race of Nordic people than any of the Scandinavian nations.

Let us now turn to the subject on hand, namely the racial origin of the Jewish people. For our purposes we shall define the word Jew to include all individuals of the so-called "White" races of mankind who, by virtue of familial tradition, do practice or whose ancestors did practise the religion of Judaism.

From the point of view of the physical anthropologist the history of the Jewish people may be conveniently divided into two main sections: (1) the formation of the Jewish people, and (2) their dispersion and related racial history. I shall, then, first consider the anthropological aspects of the formative period of Jewish history.

I think it can be fairly said that, although the forebears of the Children of Israel were already, in some respects, a distinct unit before their arrival in Palestine about 1200 B.C., it was not until after prolonged residence in this country that their formation as a nation and as a racial entity was established. The exact ultimate origin of the Children of Israel who founded the Jewish Kingdom in Palestine is not known. But from Biblical accounts, as well as from other sources, there are extremely strong indications that they were probably nomadic pastoral tribes who spoke the Semitic languages and who emigrated from somewhere along the desert border of southern Mesopotamia. Following the fringes of cultivation, these people moved northward and westward until they entered Palestine. What were they racially? There are reasons for supposing that this group must have been predominantly of Mediterranean racial stock like most of the Arabs and Mesopotamians of this area. I might pause here for a moment to explain what I mean by Mediterranean. To the physical anthropologist the term Mediterranean is applied to a sub-race of the great "White" division of mankind whose members possess the following characteristics: short stature; brunet pigmentation, that is black or dark brown hair; dark brown or light brown eyes; skin color varying from the pale white to a more prevailingly light brown and olive; head hair which is almost always wavy, sometimes curly, but rarely straight; a head form which is dolichocephalic or relatively long and narrow, flat temples, protruding occiputs or backs of the head, vertical foreheads and smoothness of bony eminences of the face and skull; faces that are symmetrically oval, narrow but not very long; and finally noses which are long and narrow but of moderate height plus a profile which is usually straight. The tip of the nose is only of moderate development in thickness and breadth with no particular tendency to exhibit any downward inclination. There are other features as well, but this will suffice for the purpose on hand. It is a racial type which may be found today in its purest form in Egyptians, in many Arab tribes in the Near East and along the northern shores of Africa, in many of the Southern Italians,

and also in certain Spanish and Portuguese groups.

The original Children of Israel were, in all probability, composed predominantly of this basic short-statured brunet Mediterranean type. Their entrance into Palestine did not take the form of a single large migratory movement but was marked by a succession of small groups who came by different routes and under different leaders. On their arrival these Jewish migrants found the following peoples in and around the Palestinian area. There were first the Amorites who were concentrated principally in the north. Next were the Canaanites who lived in that part of Palestine which bore its name until they were finally absorbed by the Jews over a period of time. And finally, there were the coastal Phillistines who very likely came from the general neighborhood of the Aegean and who were extremely active in the eastern end of the Mediterranean at about 1200 B.C. In addition, there were a number of other small tribes in the countries bordering on Palestine including the Ammon, Moab, and Edom.

It becomes important to inquire into the physical type of these peoples who occupied the Palestinian area at the time of the coming of the ancestors of the Children of Israel inasmuch as they all contributed their racial stock in varying degrees to the formation of the Jewish people. Our only source for this material is the Egyptian monuments. But it is a notable fact that the Egyptian artists had a genius for caricaturing racial features so that the important physical characters of the head and face, which are necessary for racial identification, are extraordinarily clear. From these pictorials we find that the Phillistines are represented as European-looking Mediterraneans with straight noses and light skins; the Amorites are depicted as taller and heavier set individuals with long faces, yellowish skin colors, with a long convex profiled nose, and sometimes with heavy browridges just above the eyes. The Semites in general are seen to have sloping foreheads and exaggerated long convex nasal profiles which have so often been identified as the "Jewish" nose.

It thus appears that in all probability the Phillistines were racially straight brunet Mediterranean, the Amorites and some of the Semites were Mediterranean plus a strong addition of what is now called the Iranian Plateau racial stock. The Iranian Plateau type is a very important factor in the racial set-up and history of the Jewish people and naturally deserves some extended comments. The identification of this Iranian Plateau race is the work of Dr. Henry Field of the Field Museum of Chicago. In analyzing a very extended series of anthropometric measurements and observations gathered in Iran and Iraq, he found that he was able to isolate a very distinctive brunet White race presenting the following characters: black or dark brown wavy head hair, brown eyes, very abundant beard and body hair, moderate to short stature, long and narrow heads, long and narrow faces with prominent bony structures. Undoubtedly the most outstanding feature of this race is its nasality. The nose is always very high and very prominent. The profile of the nose is sometimes straight but almost always very strongly convex or concavo-convex. The tip of the nose is usually depressed and slopes downward and is of moderate thickness with strong recurvation of the alae or nostrils. This extremely prominent nose with its convexity and depressed nasal tip is clearly an advanced evolutionary character in that it departs furthest from the anthropoidal nasal form. It is also important to note that it appears to be a very dominant feature in that it persists very strongly at the expense of other nasal types when racial strains are mixed.

I have pointed out that the Children of Israel were probably of relatively pure brunet Mediterranean stock and had entered and settled a land which was occupied by different peoples, some of whom were also pure brunet Mediterranean and others of Mediterranean blood with strong ad-

mixtures of the beak-nosed Iranian Plateau race. There followed, that long, fascinating, and sometimes glorious period in the history of the Jewish people: the emigration to Egypt, the bondage in that land, the exodus, and the return to Palestine; the period of Judges and the writhings and strugglings of a people with their final emergence as a nation and the establishment of the Kingdom of Israel under Saul; the blossoming and expansion of the Jewish culture under David and Solomon; the separation of the nation into the Kingdom of Judah and the Kingdom of the Ten Tribes; the era of the prophets, and the ultimate downfall of the divided nation which was marked by the first destruction of the Temple.

This, then, was the formative period of Jewish history, formative not only in a nationalistic and cultural sense, but also from a racial point of view. For, during all this time there was constant intermingling and absorption into the Jewish population of the original residents and neighboring peoples of the Palestinian area. This blood was principally, as I have already pointed out, Mediterranean and Iranian Plateau and probably to some extent Alpine. Study of skeletal material from early Palestine substantiate these findings inasmuch as its analysis shows that the inhabitants of the area were predominantly of Mediterranean stock with a definite element of the convex-nosed Iranian Plateau type. Such was the racial status of the Jewish people at the time of the destruction of the Temple in 586 B.C. and the beginning of the First Jewish Diaspora in Babylon.

The captivity of the Jews in Babylon was not a very long one, extending only from 586 B.C. to 538 B.C. at which time some of the Jews of Mesopotamia returned to Palestine. It should be noted that only a small part of the Jewish population in Babylon actually returned to their homeland, for the majority had already founded permanent jewish colonies in Iraq. These colonies not only continued to exist, but actually flourished, for Babylonia was the center in which Talmudic Jewish civilization developed. And from the beginning of the 3rd century A.D. to the middle of the 11th under the successive rules of the Persians and the Moslem Arabs, this focus was one of the most important in the Jewish world. This development was halted by the arrival of the Mongol hordes in the Near East when the Jewish population of Iraq shrunk from about a million inhabitants to that of a few thousands. But the racial influence of this nucleus of Mesopotamian Jews had already been rather extensive, for this was the source from which many of the present day Oriental groups of Jews were derived, particularly the Persian Jews and the Jews of Bokhara, in Russian Turkestan. Some discussion of the racial status of the Oriental Jews is pertinent here.

From the available anthropological data on the Mesopotamian Jews of today we find that, although they have, during the centuries, absorbed to a certain extend the blood of their neighbors, they still show significant differences from the non-Jews of the same area. From the Mesopotamians, they absorbed some additional convex-nosed Iranian Plateau features but have, on the whole, maintained their predominant Mediterranean strain. They are moderate to short in stature, they have long and narrow skulls as well as skulls of medium length and medium breadth, long and narrow faces, long and narrow noses with profiles that are straight and convex and display depressed tips. In addition, they show a brunet pigmentation of hair, skin and eyes. They differ from the non-Jews of Iraq in having smaller heads and faces, and longer and narrower noses. A similar situation is observable in the Jews of southern Persia but those of northern Persia have been modified to some extent by the addition of an Alpine strain which has tended towards increased roundness or brachycephalization, taller stature, broader faces, but their nose form has remained almost the same.

The Bokharan Jews of Russian Turkestan have been considerably altered from their original physical status. In this area they have practised both outbreeding and inbreeding. It is the region of the Tajiks and other Turkestan peoples. This area not only underwent extreme brachycephalization or roundheaded changes through Alpine invasions but has also seen the country overrun by Turkish and Mongol peoples. It is the opinion of Doctor Coon of Harvard University, to whom I owe a good deal of this material, that, although the Jews outbred with Alpines of Turkestan, they did not absorb, to any great extent, the incoming Mongoloid blood. They are basically Mediterranean, with some Alpine and some Iranian Plateau admixture.

If we now return to consider the Jews who had returned to Palestine from their captivity in Babylon, it becomes apparent that their sojourn in this latter country was too short in duration to have modified their racial status to any great extent. They were still a composite group composed predominantly of Mediterranean Blood with a strong Iranian Plateau element and probably some Alpine strain. The next historical period covers the founding of the new community in Judaea, the age of the prophets Ezra and Nehemiah, the Sopheric Age, the Egyptian relationships, the Hellenistic influences, the rise of the Macabees, the Roman period, the rise of Christianity, and finally the destruction of the Temple in 70 A.D. From a racial point of view this period was an era of considerable admixture of various strains in the Jewish population. The establishment of Jewish colonies in Egypt and Egyptian cultural relationships was accompanied by the commingling of Egyptian blood. This served to strengthen the Mediterranean character of the Jewish people inasmuch as the Egyptians were racially of almost pure Mediterranean stock. The influence and expansion of Hellenism also added numerous alien strains which were, for the most part, Mediterranean but which contained, in addition, some Alpine and Nordic elements. It is my opinion that, as this period progressed, there was a strong diminution in the accretions of the Iranian Plateau stock from the Mesopotamian area. The onset of the Roman era was also attended by further additions of foreign blood of predominantly Mediterranean and Alpine character. Accordingly, the racial status of the Jewish population in Palestine at the time of the second destruction of the Temple in 70 A. D. was quite complex and heterogeneous. It was a composite physical type of basic Mediterranean stock, plus a definite "beak-nosed" Iranian Plateau element with the additions of Alpine and Nordic strains. This was the generalized stock from which most of the Jews of central and western Europe were ultimately derived.

It is generally considered that the second destruction of the Temple marked the second Jewish Diaspora. As a matter of fact, the second Diaspora had already taken place following the expansion of Hellenism begun by Alexander the Great and his successors and which continued under the Byzantine Empire. This consisted of rather large streams of migration over the entire Hellenistic and Byzantine worlds. The Jews emigrated principally to new centers in Egypt, Syria and Asia Minor, but in addition established residence in the Balkans and in the area just north of the Black Sea. The second destruction of the Temple gave impetus to additional movements into these areas particularly into Crimea. The latter Jews were not affected very much by the invasions of the Goths and Huns, but were considerably altered by the arrival and establishment of the Tartar Khazars until the time when the Slavic expansions destroyed the Khazar Kingdom and scattered the remnants of the Jews eastward. It was these scattered remnants of the Byzantine Jews who became the eastern branch of the Ashkenazim.

The third or final Jewish Diaspora, which eventually emptied Palestine of Jews until the Zionist period, had started

back in Macabeean times with the first contact with the Romans and was hastened by the second destruction of the Temple. The Jews moved westward with the Romans. They not only came from Palestine but also from previously established Jewish centers of the Hellenistic period. They followed the Romans into Italy, Spain, France and Germany as far as the banks of the Rhine. The Jews in Italy formed small localized communities and have had a continuous period of occupation. At times they have been influenced by arrival of other Jews from neighboring countries. The French Jews disappeared as a unit in 1394 A.D. Uprooted by a series of mass expulsions, these people were scattered throughout the countries in the general vicinity. The Spanish Jews were ultimately driven out of Spain along with the Moors in 1492 A.D. These Jews whom I shall term Sephardic Jews were dispersed to Holland, England, Italy, to North Africa and the Balkans. It is interesting to note that the descendants of these Jews still speak today a form of Spanish known as Ladino and have many customs and cultural traits indicative of their Spanish origin. The descendants of the German Jews of the Rhineland ultimately became the most numerous element in the Jewish population of today. These we shall refer to as the Ashkenazic Jews. Although at first the German Jews were restricted to the Rhine valley, by a series of emigrations and expulsions they soon moved eastward and southward. The first large movement took place soon after the First Crusade at about 1096 A. D. when they moved eastwards into the Slavic countries. In Poland and in southern Russia these descendants of the German Jews met with and absorbed the small remnants of the Byzantine Jews, those Jews who had originally settled the northern border of the Black Sea during the Hellenistic period but who had finally been forced northward and westward. Just as the Spanish or Sephardic Jews carried with them to North Africa and to the Turkish Empire their Spanish idioms, so the descendants of the German Jews or the Ashkenazim carried with them to the Slavic countries their High German dialects which ultimately became what is now known as the Yiddish language. Both the Sephardim and the Ashkenazim, however, continued to use Hebrew as the language of their ceremonials, their education, and most of their literature.

Let us consider first the racial anthropology of the present day Sephardic Jews. These people are for the most part the descendants of the refugees from Spain and Portugal in 1492, and are today to be found principally in scattered colonies in North Africa, in the Balkans and in the general Asia Minor Area. There is a relatively large amount of anthropometric material available on these peoples, all of which makes a rather clear picture of what happened. Space, however, does not permit any detailed presentation of the data. The Sephardic Jews, as a whole, are almost as Mediterranean in racial features as the peoples within whose areas they reside. In some instances they are perhaps more Mediterranean than their neighbors. In other words, in the Sephardic Jew there has been a purification and reinforcement of their Mediterranean racial strain. Since their departure from the Palestinian area with the Hellenistic and Roman expansions these Jews have mixed with many of the perhaps purest Mediterranean strains in Spain, Portugal and North Africa. Accordingly, there was a dilution of the round-headed Alpinoid and beak-nosed Iranian Plateau elements which the Jews had obtained in the formative period of their history, with a consequent strengthening of the basic Mediterranean stock. In general, the Sephardic Jews may be said to be short to moderate in stature, rather slender in body build, with skin colors predominantly on the darker side varying from a very light brown to an olive shade. Their eyes are most commonly dark brown; the hair, brown to black and either curly or wavy in form; the head is on the long and

narrow side with protruding occiputs and presents a well rounded and high forehead. The face is characteristically small, oval, with an absence of strong, rugged and bony outlines. This delicate appearance of the face often gives a distinct "aristocratic" impression, which is heightened by the possession of a long, thin, and very high bridged nose.

The "Iranian Plateau" type of nose, with its strong convexity, and its rather thick, depressed tip, and flaring, recurved alae, is not entirely absent among the Sephardic Jews but the nose is certainly more often found to be thinner, straighter, and with less frequent depressions of the nasal tip. And finally, the Sephardic Jews possess lips which tend to be thin, rather than thick, chins which are small and not very projecting, and hands and feet which tend to be small and slender. This is the typical picture of a great many of the Sephardic Jews. However, it should be pointed out that the Sephardic Jews, who settled in the Balkan and Asia Minor areas, were modified by admixture with the Hellenized Byzantine Jews and with local ethnic groups, which in many instances has resulted in modifying their predominantly Mediterranean character in a more Alpine and Dinaric direction. These people are, on the whole, taller and heavier in body build, more round-headed, more rugged in facial characteristics, and with a greater frequency of the Iranian Plateau nasal and lip features.

We may now turn to the discussion of the Ashkenazic Jews, the Jews which form the bulk of modern European Jewry, and the stock from which most of the Jews of America have been derived. From the plethora of anthropometric data on many diverse Ashkenazic groups it appears that there is no strong homogeneity of racial type such as exists for the Sephardic Jews. The Ashkenazic Jews are extremely composite in physical features which indicates a very strongly heterogeneous racial background. It also appears that each particular European area has its own characteristic combination of racial characters so that the Jews of Germany are quite different physically than, let us say, the Jews of Poland, or the Jews of Southern Russia. It is impossible here to go into the detailed analysis of the available data on the Ashkenazic Jews. Apparently, in whatever country the Jews have settled for a long period of time, they have taken on, to a considerable extent, but not completely, the racial character of the Gentile population of that area. Thus, prior to the World War, the Jews in Germany, Lithuania, Bohemia, and Austria, possessed relatively similar racial features to the non-Jewish populations of these areas. Wherever in these regions Nordic racial strains were strongest, the Jews of such localities showed their strongest representation of Nordic features. By Nordic I refer to that primary race within the "White" group of mankind which is characterized by tall stature, blondism of skin, hair and eyes, long-headedness, straight head hair, long and narrow faces, prominent noses which are both long and narrow, and with thin nasal tips. At the same time, the Jews who lived in Poland, Galicia, northern Roumania, and White Russia resemble their Gentile neighbors throughout these areas by the possession, on the whole, of similar racial features. These are the areas of strong Alpinoid strains, racial types which are characterized by moderate stature, squat heavy set body builds, round-headedness, brunet pigmentation, relatively short broad face, noses of medium length and breadth with blobby nasal tips which are most often inclined in an upward direction. It is precisely from these regions that the Jews display their strongest Alpinoid characters.

Most of the inhabitants of these regions, Jew and Gentile, are racially mixed combinations, in different proportions, of Nordic, Alpine, Mediterranean and, to some extent, of the Dinaric and East Baltic stocks. In some areas certain of these strains come out stronger than others and their composite character may often be-

come very distinctive. Just as it is incorrect to say that the Gentiles of the Ashkenazic European areas form one single racial type, so it is impossible for anyone to relegate the Ashkenazic Jews to a single racial classification. However, there is a supplementary factor which must be taken into consideration Underlying the mixed racial status of the Ashkenazic Jews there is almost everywhere a small Mediterranean and "Iranian Plateau" element. In certain areas this Mediterranean strain is stronger than in others. In some instances it is hardly discernible. In no instance does it reach the strength and importance that it does among the Sephardic Jews. It is solely because the Iranian Plateau strain is characterized by this strongly dominant beak-like nose with its thick and depressed tip and recurved alae or nostrils that we are able to identify this element as being even present among a good deal of the Ashkenazic population. It is because this type of nose persists at the expense of other types when racial strains are mixed. It is this nasality that is the main distinctive physical character that the Ashkenazic Jews have retained from their Palestinian forebears.

All Jews, whether they be Ashkenazic, Sephardic or Oriental, have modified their original racial complex mainly through admixture with other racial stocks throughout the many centuries in the different regions of the Old World. It is my opinion that whatever physical changes the Jews have been subjected to, those of environmental origin are of very minor consequence compared to the effect brought about through actual comingling with alien racial strains. Today the Ashkenazic Jews display the whole gamut of mixed racial strains that are also present in the Gentile populations of the same European areas, with the supplementary factor, however, that underlying all these conglomerate mixtures there still remains a small Mediterranean and Iranian Plateau remnant of the original racial characters of the formative period of Jewish history in Palestine. And finally the Jews who are today settled in the United States are principally derived from the Ashkenazic branch of the Jewish people, with only very slight additions of their co-religionists of Sephardic extraction.

Are the Jews as a whole physically distinctive from the Gentiles and do they form a "Jewish Race" in the strictly anthropological sense? It is a matter of common observation that the majority of the Jews can be selected from our American population by the man in the street apparently on the basis of physical appearance. There seems to be some sort of quality of looking Jewish which is very difficult to analyze even for the anthropologist. However, there are some factors which are relatively clear. I have already pointed out that no matter what racial blends the various groups of Jewish people are composed of, virtually all possess a small remnant of Mediterranean and Iranian Plateau blood. In some Jewish people these strains are stronger than in others. The physical expression of the Iranian Plateau element is this dominant nasality. It is this very high, prominent, usually convex nose, with a thick and quite often depressed tip, and flaring and recurved nostrils, which has persisted among the Jews at the expense of other forms less distinctive. It is certainly a feature which aids in making the Jews physically distinctive. The Mediterranean strain is expressed in part by a certain thickness and eversion of the lips, together with a strong tendency towards very wavy and curly hair; and probably by prominent, widely open and large-lidded eyes. These characteristics are sometimes found in combinations and often singly, and in some instances are entirely absent. In the majority of cases, they seem to be distinctive enough to aid in the separation of Jew and Gentile, especially when these characteristics are found associated with certain extraverted social and psychological features.

Now it must be strongly emphasized that none of these physical criteria mentioned are exclusively Jewish. They are found in many other groups of the "White" division of mankind. The nasal convexity is

to be found among many Europeans, Arabs, Iranians, and other groups in the Near East and Mediterranean areas. The depression of the nasal tip and its thickness is also seen extremely frequently in non-Jews in Asia Minor. The thickness and eversion of the lips and the wide opened biconvex eyes are to be found all over Europe in many diverse groups. They are in no sense the exclusive property of the Jewish people.

Can we then say that there is such a thing as the "Jewish Race"? The answer is definitely no. In the anthropological meaning of the word "race," it can be said with conviction that the Jewish people, taken as a whole, show no preponderence, nor consistency, nor exclusiveness of physical features which allow them to be classified as a unified racial group. They are a conglomerate mixture of many races in disparate proportions bound together by common religion, familial, and historical traditions, but showing in many instances varying amounts of physical distinctiveness. We can no more classify the Jews into a race than we can say that there is an American race with its mixture of people of British, Irish, Scandinavian, French, Italian, Greek and other extractions.

"JAKE" MAGRATH

"And this, gentlemen, is a torso!" What former medical student can recall these words of Dr. Magrath without a shudder? The dark room, the grewsome lantern slides, the deep voice and stern presence—then the fellow behind you touches your neck with something cold . . . .

The Memorial which was read to the Faculty of Medicine on George Burgess Magrath, who died on December 11, 1938, is not too laudatory and seems complete. Necessary formality, however, does not permit much latitude in giving expression to the personality of this, we believe, great individual. Dr. Magrath had several professions. First, he was an authority on legal medicine and pathology. Second, he was a musician and a devoted patron of music. Third, he was an athlete. He was a member of the Union Boat Club since 1898. He held several rewards in rowing, among which was, with few rivals, taking the first and last rows on the river. He was an ardent hand-ball player. Lastly, if it is a profession, he was a delightful friend and companion to many people and a jovial asset in many different social gatherings.

His intellectual brilliance was early manifested, as is shown in the following anecdote provided by W. T. Porter: "Magrath's note-books were the most beautiful ever seen. He had two chums, each of whom afterwards became professors. These two attended no lectures except by chance. There were professors whom these two delightful creatures did not know by sight. They (the delightful two) lived by symbiosis (if I have that long word correct): they lived entirely upon Magrath's note books. At the final test, Magrath, who never missed a lecture, and his two companions, who never attended a lecture, all passed with distinction."

"Suffolk Sue" was the name of the ancient Model T Ford in which Dr. Magrath went about town. It was as unusual in appearance as its driver. Its history was somewhat as follows: It was a 1917 model (one accurate observer insists that it was much older than 1913). In it originally was a Grey and Davis starter which weighed 200 pounds and was so heavy it broke the springs several times. In 1921, another motor was put in, with a self starter. In 1932 the car was put aside and kept under a barn at the summer home in Ashburnham. Last summer two children got the car out and rolled it down a hill. It crashed at the bottom, stayed there for several months, and the last heard of it was that it had been stripped and the chassis taken to be used for a truck.

The car, as well as its owner, has been immortalized in verse by David McCord for the St. Botolph Club. Space permits only the last stanza:

"On the road to Number Four,
Where the old T-Model tore;
Can't you 'ear the carbon knockin', feel
'er shakin' at the core?
On the road to Number Four,
Where we've art and lit'rature,
An' the dawn comes up like thunder, an'
Magrath comes up for more!"

JOSEPH BRIGGS HOWLAND

An Appreciation

Joseph Briggs Howland resigned from the post of Superintendent of the Peter Bent Brigham Hospital on December 31, 1938. Shortly preceding his retirement a dinner was given to him and his friends by Mr. William Amory, President of the Board of Incorporators, as a tribute to his valuable, distinguished, and devoted service to the Hospital.

Dr. Howland has had a unique experience in hospital administration. When his medical career began, a hospital was an institution primarily for the care of indigent sick, aseptic surgery was in swaddling clothes and knowledge of the infectious diseases had just started its extraordinary and beneficient development. His administrative activities have covered the period of the greatest development of medicine, a period which included the conquest of the bacterial diseases, the far-reaching participation of the state in sanitation and in health measures, and the final growth of the hospital of today as a place which all classes of humanity rich and poor alike, look upon as the beneficent centre for the best in medical care.

Dr. Howland was born in North Bridgewater, Massachusetts, in 1873 of a typical New England family whose original ancestor, John Howland, was a passenger on the Mayflower. After early education at the Brockton Grammar and High Schools he went to the Harvard Medical School, graduating in the class of 1896, the first class to undergo a four-year period of education. During his last year he was appointed Surgical House Pupil on the West Surgical Service at the Massachusetts General Hospital which then had as its Visiting Surgeons H. H. A. Beach, Maurice H. Richardson, and Samuel J. Mixter. Though a quiet and apparently studious person, Dr. Howland had a delightful sense of humor and always saw the amusing side of episodes. Characteristic is his story of his Chief, Dr. Mixter, searching for mushrooms in the Hospital yard and locating them by feeling the mushrooms with his toes through his "sneakers."

Immediately upon finishing his hospital service, Dr. Howland started practice in Boston but was soon enticed to an administrative post at the Massachusetts State Hospital at Tewksbury, becoming Assistant Physician, 1898 to 1901. In 1901 Dr. Herbert B. Howard, then Chairman of the State Board of Insanity induced Dr. Howland to become Superintendent of the State Colony for Insane at East Gardner. At this time this State Colony was merely an idea with plans on paper, and to accomplish the practical issue of this dream Dr. Howard resigned from the State Board of Insanity to become the first Chairman of the Trustees of this State Colony. Dr. Howland moved at once to a small temporary building on the Colony grounds from which he directed the erection of the buildings on what was then a wilderness of abandoned farms and forest lands. Dr. Frederic A. Washburn tells the story of the rigors of life in the temporary shack of Dr. Howland as well as the fortitude of the latter, commenting on a visit there when he almost froze to death whereas Dr. Howland took everything as a matter of course.

Dr. Howland remained at East Gardner from 1902 to 1907, at which time Dr. Howard again persuaded him to go to the Massachusetts General Hospital as Assistant Resident Physician. Later when Dr. Howard left the Massachusetts General Hospital to assume the superintendency of and to build the Peter Bent Brigham Hospital Dr. Howland remained as First Assistant Resident Physician under Dr. Washburn. Here Dr. Howland remained from 1908 to 1919, living in the superintendent's house on the grounds and throughout the War years being acting Director while Dr. Washburn was abroad. This was a most active period for the hospital and for Dr. Howland. In the superintendent's house on the grounds of the Massachusetts General Hospital his two children were born. During this period the Phillips House, the Walcott Nurses Home,

and the Moseley Memorial Building were erected. This was not only a busy time but a difficult time for the hospital. Funds were short. A good part of the nurses and the professional personnel had gone to the War. Additional patients were cared for in a special ward set up for the sailors of the U. S. Navy, and in 1918 the hospital passed through the tremendously trying experience of the influenza epidemic.

Finally in 1919 Dr. Howland moved to the Peter Bent Brigham Hospital to succeed Dr. Howard upon the latter's retirement. Here he played a major rôle in the continued development of that institution. His steady character, his absolute honesty, his devotion to hospital labors, his good example, and his high abilities as a hospital administrator led to his recognition as a leader in hospital administration in the United States. He served as President of the American Hospital Association for the year 1919 to 1920. He was President of the New England Hospital Association for the year 1921 to 1922. He became the Administrator of the Collis P. Huntington Memorial Hospital in 1927, and has served as Secretary of the Harvard Cancer Commission since that year.

As a hospital administrator Dr. Howland came into close contact with the nursing profession and made notable contributions in this field. He gave generously of his time and knowledge to the advancement of nursing service through improved standards in nursing education. He served from 1919 to 1924 as a member of the Massachusetts State Board of Registration of Nurses, and from 1929 to 1934 he represented the American Hospital Association as a member of the National Committee on the grading of schools of nursing. His concepts of nursing as a profession broadened perceptibly during this period and his judgment was held in regard by other members of the Committee, which was composed of doctors, nurses and educators from the general field of education. His sympathetic and equable disposition was of great advantage in his relation to this field. Always ready to help when needed, never irritated, distinctly friendly and approachable, loyal, fair and just, he made friends even under trying circumstances and emerged from this contact a sure associate to whom the nursing profession turned in any time of need.

His achievements in his special field have made him much sought after as a consultant in hospital administration. His judicial mind, integrity of character, and his general appreciation of hospital problems became of great value in the organization and building programs of many institutions. It became generally known that he was the kind of person who did not always place his own ideas first, but who could take the plans of a local community group or of hospital trustees in a distant place and put them together in working form without that domination which has tended so greatly in America to regiment everything. All the time that he was doing this work he was steadily educating a group of pupils to follow in his footsteps. As a result many of his pupils fill important posts today in the hospitals of our country, and we who take pride in his having served the Peter Bent Brigham Hospital so long and faithfully rejoice that others in distant parts also have benefited from his abilities.

We who know him well have that deep affection for the man which is often strongest when least expressed. Not only could the students and internes never feel unfairness in what Dr. Howland said or did, but many rejoiced that a man so broad and generous and sane should occupy the position he so long decorated. His value as an administrator is further betokened by the fact that the Board of Incorporators of the Peter Bent Brigham Hospital asked him to stay on a period of two years longer than the age limit set for incumbents of that position. To many of us he remains the same young erect, vigorous and kind person. Age seems to have made but little dent upon either his mental or physical abilities. His humor has not changed. His hobby of building ship models to scale has

revealed both the facility with which he could conquer a precise technique as well as shown an inherent love of the sea so deeply a part of his ancestory. This little note is an attempt to say openly the many things Dr. Howland's friends would like to say but have never actually put in words.

E. C. C.

THIRTY-FIFTH REUNION

In accordance with its custom of meeting every five years since graduation, the Class of 1904 is holding its thirty-fifth reunion next June. This is to take place at the Harvard Club in Boston on Monday, June 5th. As the luncheon and meeting of the Harvard Medical Alumni Association takes place in Worcester next day, this makes it possible, especially for those coming from a distance, to take in both events, together with the meeting of the Massachusetts Medical Society, with minimum expenditure of time and travel.

Our dinner should be a pleasant and significant occasion. After being out of the School for thirty-five years and many of our classmates having died, those living should be only too happy to get together once more.

It seems that all unknowingly the Class of 1904 set an example and established a record when it voted at its fifteenth reunion to raise a sum of money to be given to the School on the occasion of its twenty-fifth anniversary. This money was raised by means of small annual installments, but not without much labor on the part of both Dr. Walter G. Phippen of Salem, who has acted as Treasurer, and the writer. In June, 1929, we were able to present the sum of $7,000 to the School, with the proviso that while the principal should be kept intact the interest might be used as decided by the Administrative Board. For some years at least a part of the interest was so used. Later, believing that this interest, even though small, might be put to better use, we asked and obtained permission to spend it for the payment of a portion of the room rent in Vanderbilt Hall for certain carefully-selected students who otherwise could not avail themselves of this privilege. This disposition of our money gave the utmost satisfaction not only to us who gave it, but also to those who were helped by it.

Since our twenty-fifth reunion we have been fortunate enough to have a few more hundreds of dollars come into the hands of our Treasurer. This, together with accumulations of interest, will enable us to bring our original gift of $7000 up to a final sum of $10,000. We intend to present this last installment of our gift to the School at our reunion next June. While discussion and correspondence with Dean Burwell has resulted as yet in no definite plan for the disposition either of our principal sum or of the interest which it draws, there is no doubt that a satisfactory solution will be found.

Dr. David Cheever, of the Class of 1901, in an article entitled "Harvard Medical Alumni Fund" published in the April, 1938, issue of the HARVARD MEDICAL ALUMNI BULLETIN reviews in extenso the history and status of all funds which have been given to the Medical School. In this article Cheever says, "Apparently the first concrete accomplishment of the suggestion of class funds made so many years ago must be credited to the Class of 1904." He then goes on to say that "the example of this class has proved contagious, for similar though smaller gifts on their twenty-fifth anniversaries have been contributed by the Classes of 1908, 1909, 1910 and 1912 . ."

The Class of 1904 notes with satisfaction that other classes have followed its example and is hopeful that the habit will be acquired by every class when its time comes. We wish to point out, however, that in order to be successful and if any more than a trivial sum is to be raised, the movement must be initiated when a class reaches its tenth or fifteenth anniversary. An annual contribution from each member of from $5 to $10 during the ensuing years would result in a very substantial sum of money—from $5000 to $7500. It may

be said that success in this effort, as in every other, can be obtained only by hard work; and this means that the burden must be borne by enthusiastic and loyal class officers.

If and when all classes fall into line, the money which is given can be combined, together with other funds, to make a very substantial principal sum. It can easily be arranged to keep the principal intact, and the Administrative Board will then find itself in the possession of what it most needs, namely money for unrestricted purposes for the various and many needs of the School.

J. Dellinger Barney,
Class of 1904.

MEDICAL SCHOOL AWARDS

The Henry Ashbury Christian Prize, one of the outstanding honors at the Harvard Medical School, has been awarded to Henry Swan, 2d, of Denver, Colo., a fourth-year student. Swan graduated from Williams College in 1935.

The prize is awarded to "the student in the fourth-year class who has displayed diligence and notable scholarship and offers promise for the future." The award was established in 1937 in honor of Dr. Henry A. Christian, Hersey Professor of the Theory and Practice of Physic, who has been a member of the Medical School staff since 1902.

ALUMNI DINNER IN ST. LOUIS

The Association is sponsoring a dinner for Alumni during the annual meeting of the American Medical Association in St. Louis. The dinner will be held on Wednesday, May 17, at 7 o'clock at the University Club. Dr. Archer O'Reilly, Chairman of the Committee on Arrangements, (3534 Washington Blvd., St. Louis, Mo.) would appreciate hearing by May 10 from those who expect to attend so that the arrangements may be completed. The price of the dinner will be $3.00.

ANNUAL MEETING

The luncheon and annual meeting of the Harvard Medical Alumni Association will be held at the Hotel Bancroft, Worcester, at 12.30, on Tuesday, June 6, 1939. The meeting preceeding the luncheon will be brief. Dean Burwell will speak for a few minutes and three new councillors will be elected. The charge for the luncheon will be $1.00. Tickets will be on sale at the registration desk.

The meeting is in conjunction with the annual meeting of the Massachusetts Medical Society which opens at the Bancroft on the same date.

TWENTY-FIFTH REUNION

The Twenty-fifth Anniversary of the Class of 1914 will be celebrated on June 9th and 10th. The class will meet at the Harvard Club for luncheon on June 9th and then will go to the Hoosic Whisick Club for an afternoon of golf and good fellowship. The class dinner will be held that evening, at which the guest of honor will be Dr. Walter Cannon. Also, on Friday afternoon the wives of the class members will meet at a tea given at the home of Mrs. Donald Munro, and that same evening they will attend a Pop concert at Symphony Hall. On Saturday morning, the members of the class will meet at the Harvard Medical School, where they will be greeted by President Emeritus Lowell and Dean Burwell. The celebration will close with luncheon that day.

The committee of arrangements is as follows:

Dr. W. Richard Ohler, *Sec'y.*
Dr. Samuel A. Levine, *Treas.*
Dr. Frederick T. Hill — Dr. Donald Munro
Dr. Peirce H. Leavitt — Dr. Raymond R. Root
Dr. Lawrence Lunt — Dr. Harry Solomon
Dr. M. N. Smith-Petersen

CORRECTION

In the issue of January, 1939, the signature of the review of "Socialized Medicine in the Soviet Union" should be Douglass V. Brown, Ph.D.